provision impinges on freedoms protected by the first amendment. And, the first amendment has no greater champion than the distinguished majority leader and certainly myself. I have worked to ensue that this provision will not violate the Constitution or place inappropriate restrictions on cherished first amendment freedoms. Nothing in this provision prohibits the free exercise of religion or speech, or impinges on the freedom of association. Moreover, nothing in the Constitution provides the right to engage in violence against fellow citizens. Aiding and financing terrorist bombings is not constitutionally protected activity. Additionally, I have to believe that honest donors to any organization would want to know if their contributions were being used for such scurrilous purposes.

Our bill provides for numerous other needed improvements in the law to fight the scourge of terrorism, including the authorization of in additional appropriations—nearly $1.6 billion—to Federal law enforcement to beef up counterterrorism efforts and increasing the maximum rewards permitted for information concerning international terrorism.

I would note that many of the provisions in this bill enjoy broad, bipartisan support and, in several cases, have passed the Senate on previous occasions. Indeed, many of the provisions in this bill have the active support of the Clinton administration. And I believe, as the President reads this bill, he will support the whole bill.

The people of the United States and around the world must know that this is an issue that transcends politics and political parties. Our resolve in this matter must be clear: our response to the terrorist threat, and to acts of terrorism, will be certain, swift, and unified.

Mr. President, ours is a free society. Our liberties, the openness of our institutions, and our freedom of movement are what make America a Nation we are willing to defend. These freedoms are cherished by virtually every American.

But this freedom is not without its costs. Because we are so open, we are vulnerable to those who would take advantage of our liberty to inflict terror on us. The horrific events of last week in Oklahoma City tragically demonstrate the price we pay for our liberty. Indeed, anyone who would do such an act, and call it a defense of liberty, mocks that word.

We must now redouble our efforts to combat terrorism and to protect our citizens. A worthy first step in the enactment of these sound provisions to provide law enforcement with the tools to fight terrorism.

Again, I thank our majority leader. Without him, we would not be this far along. Without him, this bill would not be nearly as good. Without his leadership, it probably would have grave difficulties. But with his leadership and with the work that he and his staff have put in, along with staff of other members of the Judiciary Committee, we have a bill that we believe is sound. We believe it is efficient. We believe it is fair. We believe it takes care of constitutional rights and liberties. And we believe that it will solve the problem in the future and give law enforcement the tools and the teeth in order to take the big bite of out of terrorism worldwide, but especially in our country that needs to be taken.

I urge all of our colleagues to support this legislation and again I thank our distinguished majority leader.

ADDITIONAL COSPONSORS

S. 45

At the request of Mr. FEINGOLD, the name of the Senator from South Dakota [Mr. DASCHLE] was added as a cosponsor of S. 45, a bill to amend the Helium Act to require the Secretary of the Interior to sell Federal real and personal property held in connection with activities carried out under the Helium Act, and for other purposes.

S. 240

At the request of Mr. DOMENICI, the names of the Senator from Iowa [Mr. GRASSLEY], the Senator from Alaska [Mr. MURKOWSKI], the Senator from Michigan [Mr. ABRAHAM], and the Senator from New Mexico [Mr. BINGAMAN] were added as cosponsors of S. 240, a bill to amend the Securities Exchange Act of 1934 to establish a filing deadline and to provide certain safeguards to ensure that the interests of investors are well protected under the implied private action provisions of the act.

S. 256

At the request of Mr. DOLE, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of S. 256, a bill to amend title 10, United States Code, to establish procedures for determining the status of certain missing members of the Armed Forces and certain civilians, and for other purposes.

S. 434

At the request of Mr. KOHL, the name of the Senator from Iowa [Mr. HARKIN] was added as a cosponsor of S. 434, a bill to amend the Internal Revenue Code of 1986 to increase the deductibility of business meal expenses for individuals who are subject to Federal limitations on hours of service.

S. 571

At the request of Mrs. BOXER, the names of the Senator from Washington [Mrs. MURRAY] and the Senator from Maine [Ms. SNOWE] were added as cosponsors of S. 571, a bill to amend title 10, United States Code, to terminate entitlement of pay and allowances for members of the Armed Forces who are sentenced to confinement and a punitive discharge or dismissal, and for other purposes.

S. 726

At the request of Mr. MCCAIN, the name of the Senator from New York [Mr. D'AMATO] was added as a cosponsor of S. 726, a bill to amend the Iran-Iraq Arms Non-Proliferation Act of 1992 to revise the sanctions applicable to violations of that act, and for other purposes.

SENATE RESOLUTION 112—COMMENDING THE SENATE ENROLLING CLERK UPON HIS RETIREMENT

Mr. DOLE (for himself and Mr. DASCHLE) submitted the following resolution; which was considered and agreed to:

S. RES. 112

Whereas Brian Hallen will retire from the United States Senate after almost 30 years of Government service;

Whereas he served the United States Senate for over 20 years; the last 9 years as the Enrolling Clerk;

Whereas his dedication to the United States Senate resulted in the computerization of the engrossing and enrolling process;

Whereas he has performed the duties of his office with remarkable diligence, perseverance, efficiency and intelligence;

Whereas he has faithfully performed his duties serving all Members of the Senate and House of Representatives with great professional integrity; and

Whereas Brian Hallen has earned the respect, affection and esteem of the United States Senate: Now, therefore, be it

Resolved, That the United States Senate commends Brian Hallen for his long, faithful and exemplary service to his country and to the Senate.

SEC. 2. The Secretary shall transmit a copy of this resolution to Brian Hallen.

AMENDMENTS SUBMITTED

THE COMMON SENSE LEGAL STANDARDS REFORM ACT OF 1995; COMMON SENSE PRODUCT LIABILITY REFORM ACT OF 1995

MCCONNELL (AND OTHERS) AMENDMENT NO. 603

Mr. MCCONNELL (for himself, Mr. LIEBERMAN, and Mrs. KASSEBAUM) proposed an amendment to amendment No. 596 proposed by Mr. GORTON to the bill (H.R. 956) to establish legal standards and procedures for product liability litigation, and for other purposes; as follows:

At the end of the pending amendment, add the following new title:

TITLE ____—HEALTH CARE LIABILITY REFORM

SEC. ___01. SHORT TITLE.

This title may be cited as the "Health Care Liability Reform and Quality Assurance Act of 1995".

Subtitle A—Health Care Liability Reform

SEC. ___11. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds the following:

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—The civil justice system of the United States is a costly and inefficient mechanism for resolving claims of health care liability and compensating injured patients and the problems associated with the current

system are having an adverse impact on the availability of, and access to, health care services and the cost of health care in the United States.

(2) EFFECT ON INTERSTATE COMMERCE.—The health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance purchased by participants in the health care system.

(3) EFFECT ON FEDERAL SPENDING.—The health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide such individuals with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reform that is designed to—

(1) ensure that individuals with meritorious health care injury claims receive fair and adequate compensation;

(2) improve the availability of health care service in cases in which health care liability actions have been shown to be a factor in the decreased availability of services; and

(3) improve the fairness and cost-effectiveness of the current health care liability system of the United States to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty and unpredictability in the amount of compensation provided to injured individuals.

SEC. ___12. DEFINITIONS.

As used in this subtitle:

(1) CLAIMANT.—The term ''claimant'' means any person who commences a health care liability action, and any person on whose behalf such an action is commenced, including the decedent in the case of an action brought through or on behalf of an estate.

(2) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' means that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(3) COLLATERAL SOURCE RULE.—The term ''collateral source rule'' means a rule, either statutorily established or established at common law, that prevents the introduction of evidence regarding collateral source benefits or that prohibits the deduction of collateral source benefits from an award of damages in a health care liability action.

(4) ECONOMIC LOSSES.—The term ''economic losses'' means objectively verifiable monetary losses incurred as a result of the provision of (or failure to provide or pay for) health care services or the use of a medical product, including past and future medical expenses, loss of past and future earnings, cost of obtaining replacement services in the home (including child care, transportation, food preparation, and household care), cost of making reasonable accommodations to a personal residence, loss of employment, and loss of business or employment opportunities. Economic losses are neither noneconomic losses nor punitive damages.

(5) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action against a health care provider, health care professional, health plan, or other defendant, including a right to legal or equitable contribution, indemnity, subrogation, third-party claims, cross claims, or counter-claims, in which the claimant alleges injury related to the provision of, payment for, or the failure to provide or pay for, health care services or medical products, regardless of the theory of liability on which the action is based. Such term does not include a product liability action, except where such an action is brought as part of a broader health care liability action.

(6) HEALTH PLAN.—The term ''health plan'' means any person or entity which is obligated to provide or pay for health benefits under any health insurance arrangement, including any person or entity acting under a contract or arrangement to provide, arrange for, or administer any health benefit.

(7) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by Federal or State laws or regulations to be licensed, registered or certified to provide such services or who is certified to provide health care services pursuant to a program of education, training and examination by an accredited institution, professional board, or professional organization.

(8) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care items or services in a State and that is required by Federal or State laws or regulations to be licensed, registered or certified to engage in the delivery of such items or services.

(9) HEALTH CARE SERVICES.—The term ''health care services'' means any services provided by a health care professional, health care provider, or health plan or any individual working under the supervision of a health care professional, that relate to the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.

(10) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a health care liability action.

(11) MEDICAL PRODUCT.—The term ''medical product'' means a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device as defined in section 201(h) of such Act (21 U.S.C. 321(h)), including any component or raw material used therein, but excluding health care services, as defined in paragraph (9).

(12) NONECONOMIC LOSSES.—The term ''noneconomic losses'' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, loss of society or companionship (other than loss of domestic services), and other nonpecuniary losses incurred by an individual with respect to which a health care liability action is brought. Noneconomic losses are neither economic losses nor punitive damages.

(13) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not for compensatory purposes, against a health care professional, health care provider, or other defendant in a health care liability action. Punitive damages are neither economic nor noneconomic damages.

(14) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(15) STATE.—The term ''State'' means each of the several States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. ___13. APPLICABILITY.

(a) IN GENERAL.—Except as provided in subsection (c), this subtitle shall apply with respect to any health care liability action brought in any Federal or State court, except that this subtitle shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) PREEMPTION.—

(1) IN GENERAL.—The provisions of this subtitle shall preempt State law only to the extent that such law is inconsistent with the limitations contained in such provisions and shall not preempt State law to the extent that such law—

(A) places greater restrictions on the amount of or standards for awarding noneconomic or punitive damages;

(B) places greater limitations on the awarding of attorneys fees for awards in excess of $150,000;

(C) permits a lower threshold for the periodic payment of future damages;

(D) establishes a shorter period during which a health care liability action may be initiated or a more restrictive rule with respect to the time at which the period of limitations begins to run; or

(E) implements collateral source rule reform that either permits the introduction of evidence of collateral source benefits or provides for the mandatory offset of collateral source benefits from damage awards.

(2) RULES OF CONSTRUCTION.—The provisions of this subtitle shall not be construed to preempt any State law that—

(A) permits State officials to commence health care liability actions as a representative of an individual;

(B) permits provider-based dispute resolution;

(C) places a maximum limit on the total damages in a health care liability action;

(D) places a maximum limit on the time in which a health care liability action may be initiated; or

(E) provides for defenses in addition to those contained in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to actions brought by a foreign nation or a citizen of a foreign nation;

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss an action of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum; or

(6) supersede any provision of Federal law.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. ___14. STATUTE OF LIMITATIONS.

A health care liability action that is subject to this title may not be initiated unless

a complaint with respect to such action is filed within the 2-year period beginning on the date on which the claimant discovered or, in the exercise of reasonable care, should have discovered the injury and its cause, except that such an action relating to a claimant under legal disability may be filed within 2 years after the date on which the disability ceases. If the commencement of a health care liability action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

SEC. ___15. REFORM OF PUNITIVE DAMAGES.

(a) LIMITATION.—With respect to a health care liability action, an award for punitive damages may only be made, if otherwise permitted by applicable law, if it is proven by clear and convincing evidence that the defendant—

(1) intended to injure the claimant for a reason unrelated to the provision of health care services;

(2) understood the claimant was substantially certain to suffer unnecessary injury, and in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; or

(3) acted with a conscious, flagrant disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid in a manner which constitutes a gross deviation from the normal standard of conduct in such circumstances.

(b) PUNITIVE DAMAGES NOT PERMITTED.—Notwithstanding the provisions of subsection (a), punitive damages may not be awarded against a defendant with respect to any health care liability action if no judgment for compensatory damages, including nominal damages (under $500), is rendered against the defendant.

(c) SEPARATE PROCEEDING.—

(1) IN GENERAL.—At the request of any defendant in a health care liability action, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; or

(B) the amount of punitive damages following a determination of punitive liability.

(2) ONLY RELEVANT EVIDENCE ADMISSIBLE.—If a defendant requests a separate proceeding under paragraph (1), evidence relevant only to the claim of punitive damages in a health care liability action, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(d) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—In determining the amount of punitive damages in a health care liability action, the trier of fact shall consider only the following:

(1) The severity of the harm caused by the conduct of the defendant.

(2) The duration of the conduct or any concealment of such conduct by the defendant.

(3) The profitability of the conduct of the defendant.

(4) The number of products sold or medical procedures rendered for compensation, as the case may be, by the defendant of the kind causing the harm complained of by the claimant.

(5) Evidence with respect to awards of punitive or exemplary damages to persons similarly situated to the claimant, when offered by the defendant.

(6) Prospective awards of compensatory damages to persons similarly situated to the claimant.

(7) Evidence with respect to any criminal or administrative penalties imposed on the defendant as a result of the conduct complained of by the claimant, when offered by the defendant.

(8) Evidence with respect to the amount of any civil fines assessed against the defendant as a result of the conduct complained of by the claimant, when offered by the defendant.

(e) LIMITATION AMOUNT.—The amount of damages that may be awarded as punitive damages in any health care liability action shall not exceed 3 times the amount awarded to the claimant for the economic injury on which such claim is based, or $250,000, whichever is greater. This subsection shall be applied by the court and shall not be disclosed to the jury.

(f) RESTRICTIONS PERMITTED.—Nothing in this title shall be construed to imply a right to seek punitive damages where none exists under Federal or State law.

SEC. ___16. PERIODIC PAYMENTS.

With respect to a health care liability action, if the award of future damages exceeds $100,000, the adjudicating body shall, at the request of either party, enter a judgment ordering that future damages be paid on a periodic basis in accordance with the guidelines contained in the Uniform Periodic Payments of Judgments Act, as promulgated by the National Conference of Commissioners on Uniform State Laws in July of 1990. The adjudicating body may waive the requirements of this section if such body determines that such a waiver is in the interests of justice.

SEC. ___17. SCOPE OF LIABILITY.

(a) IN GENERAL.—With respect to punitive and noneconomic damages, the liability of each defendant in a health care liability action shall be several only and may not be joint. Such a defendant shall be liable only for the amount of punitive or noneconomic damages allocated to the defendant in direct proportion to such defendant's percentage of fault or responsibility for the injury suffered by the claimant.

(b) DETERMINATION OF PERCENTAGE OF LIABILITY.—With respect to punitive or noneconomic damages, the trier of fact in a health care liability action shall determine the extent of each party's fault or responsibility for injury suffered by the claimant, and shall assign a percentage of responsibility for such injury to each such party.

SEC. ___18. MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.

(a) IN GENERAL.—With respect to a health care liability action, the total amount of damages received by an individual under such action shall be reduced, in accordance with subsection (b), by any other payment that has been, or will be, made to an individual to compensate such individual for the injury that was the subject of such action.

(b) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury shall be reduced under subsection (a) shall be—

(1) the total amount of any payments (other than such award) that have been made or that will be made to such individual to pay costs of or compensate such individual for the injury that was the subject of the action; minus

(2) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in paragraph (1).

(c) DETERMINATION OF AMOUNTS FROM COLLATERAL SERVICES.—The reductions required under subsection (b) shall be determined by the court in a pretrial proceeding. At the subsequent trial—

(1) no evidence shall be admitted as to the amount of any charge, payments, or damage for which a claimant—

(A) has received payment from a collateral source or the obligation for which has been assured by a third party; or

(B) is, or with reasonable certainty, will be eligible to receive payment from a collateral source of the obligation which will, with reasonable certainty be assumed by a third party; and

(2) the jury, if any, shall be advised that—

(A) except for damages as to which the court permits the introduction of evidence, the claimant's medical expenses and lost income have been or will be paid by a collateral source or third party; and

(B) the claimant shall receive no award for any damages that have been or will be paid by a collateral source or third party.

SEC. ___19. TREATMENT OF ATTORNEYS' FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a health care liability action may not charge, demand, receive, or collect for services rendered in connection with such action in excess of the following amount recovered by judgment or settlement under such action:

(A) 33⅓ percent of the first $150,000 (or portion thereof) recovered, based on after-tax recovery, plus

(B) 25 percent of any amount in excess of $150,000 recovered, based on after-tax recovery.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. ___20. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) ESTABLISHMENT BY STATES.—Each State is encouraged to establish or maintain alternative dispute resolution mechanisms that promote the resolution of health care liability claims in a manner that—

(1) is affordable for the parties involved in the claims;

(2) provides for the timely resolution of claims; and

(3) provides the parties with convenient access to the dispute resolution process.

(b) GUIDELINES.—The Attorney General, in consultation with the Secretary and the Administrative Conference of the United States, shall develop guidelines with respect to alternative dispute resolution mechanisms that may be established by States for the resolution of health care liability claims. Such guidelines shall include procedures with respect to the following methods of alternative dispute resolution:

(1) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution process which may, subject to subsection (c), result in a final decision as to facts, law, liability or damages. The parties may elect binding arbitration.

(2) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(3) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement.

If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(4) EARLY OFFER AND RECOVERY MECHANISM.—The use of early offer and recovery mechanisms under which a health care provider, health care organization, or any other alleged responsible defendant may offer to compensate a claimant for his or her reasonable economic damages, including future economic damages, less amounts available from collateral sources.

(5) CERTIFICATE OF MERIT.—The requirement that a claimant in a health care liability action submit to the court before trial a written report by a qualified specialist that includes the specialist's determination that, after a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

(6) NO FAULT.—The use of a no-fault statute under which certain health care liability actions are barred and claimants are compensated for injuries through their health plans or through other appropriate mechanisms.

(c) FURTHER REDRESS.—

IN GENERAL.—The extent to which any party may seek further redress (subsequent to a decision of an alternative dispute resolution method) concerning a health care liability claim in a Federal or State court shall be dependent upon the methods of alternative dispute resolution adopted by the State.

(d) TECHNICAL ASSISTANCE AND EVALUATIONS.—

(1) TECHNICAL ASSISTANCE.—The Attorney General may provide States with technical assistance in establishing or maintaining alternative dispute resolution mechanisms under this section.

(2) EVALUATIONS.—The Attorney General, in consultation with the Secretary and the Administrative Conference of the United States, shall monitor and evaluate the effectiveness of State alternative dispute resolution mechanisms established or maintained under this section.

SEC. ___21. APPLICABILITY.

This title shall apply to all civil actions covered under this title that are commenced on or after the date of enactment of this title, including any such action with respect to which the harm asserted in the action or the conduct that caused the injury occurred before the date of enactment of this title.

Subtitle B—Protection of the Health and Safety of Patients

SEC. ___31. ADDITIONAL RESOURCES FOR STATE HEALTH CARE QUALITY ASSURANCE AND ACCESS ACTIVITIES.

Each State shall require that not less than 50 percent of all awards of punitive damages resulting from all health care liability actions in that State, if punitive damages are otherwise permitted by applicable law, be used for activities relating to—

(1) the licensing, investigating, disciplining, and certification of health care professionals in the State; and

(2) the reduction of malpractice-related costs for health care providers volunteering to provide health care services in medically underserved areas.

SEC. ___32. QUALITY ASSURANCE, PATIENT SAFETY, AND CONSUMER INFORMATION.

(a) ADVISORY PANEL.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this title, the Administrator of the Agency for Health Care Policy and Research (hereafter referred to in this section as the ''Administrator'') shall establish an advisory panel to coordinate and evaluate, methods, procedures, and data to enhance the quality, safety, and effectiveness of health care services provided to patients.

(2) PARTICIPATION.—In establishing the advisory panel under paragraph (1), the Administrator shall ensure that members of the panel include representatives of public and private sector entities having expertise in quality assurance, risk assessment, risk management, patient safety, and patient satisfaction.

(3) OBJECTIVES.—In carrying out the duties described in this section, the Administrator, acting through the advisory panel established under paragraph (1), shall conduct a survey of public and private entities involved in quality assurance, risk assessment, patient safety, patient satisfaction, and practitioner licensing. Such survey shall include the gathering of data with respect to—

(A) performance measures of quality for health care providers and health plans;

(B) developments in survey methodology, sampling, and audit methods;

(C) methods of medical practice and patterns, and patient outcomes; and

(D) methods of disseminating information concerning successful health care quality improvement programs, risk management and patient safety programs, practice guidelines, patient satisfaction, and practitioner licensing.

(b) GUIDELINES.—Not later than 2 years after the date of enactment of this title, the Administrator shall, in accordance with chapter 5 of title 5, United States Code, establish health care quality assurance, patient safety and consumer information guidelines. Such guidelines shall be modified periodically when determined appropriate by the Administrator. Such guidelines shall be advisory in nature and not binding.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 6 months after the date of enactment of this title, the Administrator shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives, a report that contains—

(A) data concerning the availability of information relating to risk management, quality assessment, patient safety, and patient satisfaction;

(B) an estimation of the degree of consensus concerning the accuracy and content of the information available under subparagraph (A);

(C) a summary of the best practices used in the public and private sectors for disseminating information to consumers; and

(D) an evaluation of the National Practitioner Data Bank (as established under the Health Quality Improvement Act of 1986), for reliability and validity of the data and the effectiveness of the Data Bank in assisting hospitals and medical groups in overseeing the quality of practitioners.

(2) INTERIM REPORT.—Not later than 1 year after the date of enactment of this title, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report, based on the results of the advisory panel survey conducted under subsection (a)(3), concerning—

(A) the consensus of indicators of patient safety and risk;

(B) an assessment of the consumer perspective on health care quality that includes an examination of—

(i) the information most often requested by consumers;

(ii) the types of technical quality information that consumers find compelling;

(iii) the amount of information that consumers consider to be sufficient and the amount of such information considered overwhelming; and

(iv) the manner in which such information should be presented;

and recommendations for increasing the awareness of consumers concerning such information;

(C) proposed methods, building on existing data gathering and dissemination systems, for ensuring that such data is available and accessible to consumers, employers, hospitals, and patients;

(D) the existence of legal, regulatory, and practical obstacles to making such data available and accessible to consumers;

(E) privacy or proprietary issues involving the dissemination of such data;

(F) an assessment of the appropriateness of collecting such data at the Federal or State level;

(G) an evaluation of the value of permitting consumers to have access to information contained in the National Practitioner Data Bank and recommendations to improve the reliability and validity of the information; and

(H) the reliability and validity of data collected by the State medical boards and recommendations for developing investigation protocols.

(3) ANNUAL REPORT.—Not later than 1 year after the date of the submission of the report under paragraph (2), and each year thereafter, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report concerning the progress of the advisory panel in the development of a consensus with respect to the findings of the panel and in the development and modification of the guidelines required under subsection (b).

(4) TERMINATION.—The advisory panel shall terminate on the date that is 3 years after the date of enactment of this title.

Subtitle C—Severability

SEC. ___41. SEVERABILITY.

If any provision of this title, an amendment made by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments made by this title, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

THOMAS AMENDMENT NO. 604

Mr. THOMAS proposed an amendment to amendment No. 603 proposed by Mr. MCCONNELL to amendment No. 596 proposed by Mr. GORTON to the bill H.R. 956, supra; as follows:

At the appropriate place in the amendment insert the following new section:

SEC. . SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a health care liability claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of the fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice in which any of whose members previously treated the individual for the pregnancy or is providing services to the individual during

labor or the delivery of a baby pursuant to an agreement with another professional.

WELLSTONE AMENDMENT NO. 605

Mr. WELLSTONE proposed an amendment to amendment No. 603 proposed by Mr. MCCONNELL to the amendment No. 596 proposed by Mr. GORTON to the bill H.R. 956, supra; as follows:

In section ___32(c)(1) of the amendment, strike subparagraph (B) and all that follows through the end of the section and insert the following:

(B) an estimation of the degree of consensus concerning the accuracy and content of the information available under subparagraph (A); and

(C) a summary of the best practices used in the public and private sectors for disseminating information to consumers.

(2) INTERIM REPORT.—Not later than 1 year after the date of enactment of this title, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report, based on the results of the advisory panel survey conducted under subsection (a)(3), concerning—

(A) the consensus of indicators of patient safety and risk;

(B) an assessment of the consumer perspective on health care quality that includes an examination of—

(i) the information most often requested by consumers;

(ii) the types of technical quality information that consumers find compelling;

(iii) the amount of information that consumers consider to be sufficient and the amount of such information considered overwhelming; and

(iv) the manner in which such information should be presented;

and recommendations for increasing the awareness of consumers concerning such information;

(C) proposed methods, building on existing data gathering and dissemination systems, for ensuring that such data is available and accessible to consumers, employers, hospitals, and patients;

(D) the existence of legal, regulatory, and practical obstacles to making such data available and accessible to consumers;

(E) privacy or proprietary issues involving the dissemination of such data;

(F) an assessment of the appropriateness of collecting such data at the Federal or State level; and

(G) the reliability and validity of data collected by the State medical boards and recommendations for developing investigation protocols.

(3) ANNUAL REPORT.—Not later than 1 year after the date of the submission of the report under paragraph (2), and each year thereafter, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report concerning the progress of the advisory panel in the development of a consensus with respect to the findings of the panel and in the development and modification of the guidelines required under subsection (b).

(4) TERMINATION.—The advisory panel shall terminate on the date that is 3 years after the date of enactment of this title.

SEC. ___33. REQUIRING REPORTS ON MEDICAL MALPRACTICE DATA.

(a) IN GENERAL.—Section 421 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131) is amended—

(1) by striking subsections (a) and (b);

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively;

(3) by inserting before subsection (d) (as redesignated by paragraph (2)) the following subsections:

''(a) IN GENERAL.—

''(1) REQUIREMENT OF REPORTING.—Subject to paragraphs (2) and (3), each person or entity which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances of the payment.

''(2) PAYMENTS BY PRACTITIONERS.—Except as provided in paragraph (3), the persons to whom paragraph (1) applies include a physician, or other licensed health care practitioner, who makes a payment described in such paragraph and whose act or omission is the basis of the action or claim involved.

''(3) REFUND OF FEES.—With respect to a physician, or other licensed health care practitioner, whose act or omission is the basis of an action or claim described in paragraph (1), such paragraph shall not apply to a payment described in such paragraph if—

''(A) the payment is made by the physician or practitioner or entity as a refund of fees for the health services involved; and

''(B) the payment does not exceed the amount of the original charge for the health services.

''(b) INFORMATION TO BE REPORTED.—The information to be reported under subsection (a) by a person or entity regarding a payment and an action or claim includes the following:

''(1)(A)(i) The name of each physician or other licensed health care practitioner whose act or omission is the basis of the action or claim.

''(ii) To the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.), the social security account number assigned to the physician or practitioner.

''(B) If the physician or practitioner may not be identified for purposes of subparagraph (A)—

''(i) a statement of such fact and an explanation of the inability to make the identification; and

''(ii) the name of the hospital or other health services organization for whose benefit the payment was made.

''(2) The amount of the payment.

''(3) The name (if known) of any hospital or other health services organization with which the physician or practitioner is affiliated or associated.

''(4)(A) A statement describing the act or omission, and injury or illness, upon which the action or claim is based.

''(B) A statement by the physician or practitioner regarding the action or claim, if the physician or practitioner elects to make such a statement.

''(C) If the payment was made without the consent of the physician or practitioner, a statement specifying such fact and the reasons underlying the decision to make the payment without such consent.

''(5) Such other information as the Secretary determines is required for appropriate interpretation of information reported under this subsection.

''(c) CERTAIN REPORTING CRITERIA; NOTICE TO PRACTITIONERS.—

''(1) REPORTING CRITERIA.—The Secretary shall establish criteria regarding statements described in subsection (b)(4). Such criteria shall include—

''(A) criteria regarding the length of each of the statements;

''(B) criteria for entities regarding the notice required by paragraph (2), including criteria regarding the date by which—

''(i) the entity is to provide the notice; and

''(ii) the physician or practitioner is to submit the statement described in subsection (b)(4)(B) to the entity; and

''(C) such other criteria as the Secretary determines appropriate.

''(2) NOTICE OF OPPORTUNITY TO MAKE A STATEMENT.—In the case of an entity that prepares a report under subsection (a)(1) regarding a payment and an action or claim, the entity shall notify any physician or practitioner identified under subsection (b)(1)(A) of the opportunity to make a statement under subsection (b)(4)(B).''; and

(3) by adding at the end the following new subsection:

''(f) DEFINITIONS OF ENTITY AND PERSON.—For purposes of this section—

''(1) the term 'entity' includes the Federal Government, any State or local government, and any insurance company or other private organization; and

''(2) the term 'person' includes a Federal officer or a Federal employee.''.

(b) DEFINITION OF HEALTH SERVICES ORGANIZATION.—Section 431 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151) is amended—

(1) by redesignating paragraphs (5) through (14) as paragraphs (6) through (15), respectively; and

(2) by inserting after paragraph (4) the following paragraph:

''(5) The term 'health services organization' means an entity that, directly or through contracts or other arrangements, provides health services. Such term includes a hospital, health maintenance organization or another health plan organization, and a health care entity.''.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—The Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.) is amended—

(A) in section 411(a)(1), in the matter preceding subparagraph (A), by striking ''431(9)'' and inserting ''431(10)'';

(B) in section 421(d) (as redesignated by subsection (a)(2)), by inserting ''person or'' before ''entity'';

(C) in section 422(a)(2)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.)) the social security account number assigned to the physician''; and

(D) in section 423(a)(3)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.)) the social security account number assigned to the physician or practitioner''.

(2) APPLICABILITY OF REQUIREMENTS TO FEDERAL ENTITIES.—

(A) APPLICABILITY TO FEDERAL FACILITIES AND PHYSICIANS.—Section 423 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11133) is amended by adding at the end the following subsection:

''(e) APPLICABILITY TO FEDERAL FACILITIES AND PHYSICIANS.—

''(1) IN GENERAL.—Subsection (a) applies to Federal health facilities (including hospitals) and actions by such facilities regarding the competence or professional conduct of physicians employed by the Federal Government to the same extent and in the same manner as such subsection applies to health care entities and professional review actions.

''(2) RELEVANT BOARD OF MEDICAL EXAMINERS.—For purposes of paragraph (1), the Board of Medical Examiners to which a Federal health facility is to report is the Board of Medical Examiners of the State within which the facility is located.''.

(B) APPLICABILITY TO FEDERAL HOSPITALS.—Section 425 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11135) is

amended by adding at the end the following subsection:

''(d) APPLICABILITY TO FEDERAL HOSPITALS.—Subsections (a), (b), and (c) apply to hospitals under the jurisdiction of the Federal Government to the same extent and in the same manner as such subsections apply to other hospitals.''.

(C) MEMORANDA OF UNDERSTANDING.—Section 432 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11152) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

SEC. ___34. ADDITIONAL PROVISIONS REGARDING ACCESS TO INFORMATION; MISCELLANEOUS PROVISIONS.

(a) ACCESS TO INFORMATION.—Section 427(a) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137(a)) is amended to read as follows:

''(a) ACCESS REGARDING LICENSING, EMPLOYMENT, AND CLINICAL PRIVILEGES.—The Secretary (or the agency designated under section 424(b)) shall, on request, provide information reported under this part concerning a physician or other licensed health care practitioner to—

''(1) State licensing boards; and

''(2) hospitals and other health services organizations—

''(A) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner; or

''(B) to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.''.

(b) ADDITIONAL DISCLOSURES OF INFORMATION.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended by adding at the end the following subsection:

''(e) AVAILABILITY OF INFORMATION TO PUBLIC.—

''(1) REPORTS, GUIDELINES AND REGULATIONS.—

''(A) INITIAL REPORT.—Not later than 3 months after the date of enactment of the Health Care Liability Reform and Quality Assurance Act of 1995, the Secretary shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains recommendations for improving the reliability and validity of such information.

''(B) GUIDELINES AND REGULATIONS.—Not later than 180 days after the date of enactment of the Health Care Liability Reform and Quality Assurance Act of 1995, the Secretary shall establish guidelines and promulgate regulations providing for the dissemination of information to the public under sections 421, 422, and 423 of the Health Care Quality Improvement Act of 1986. With respect to such guidelines and regulations the Secretary shall determine whether information respecting small payments reported under section 421 shall be disclosed to the public. In addition, the Secretary shall ensure that such information shall include information on the expected norm for information reported under such section 421 for a physician's or practitioner's specialty. Such expected norm shall be based on assessments that are clinically and statistically valid as determined by the Secretary, in consultation with individuals with expertise in the area of medical malpractice, consumer representatives, and certain other interested parties that the Secretary determines are appropriate.''.

(c) CONFORMING AMENDMENTS.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended—

(1) in subsection (b)(1), in the first sentence, by striking ''Information reported'' and inserting ''Except for information disclosed under subsection (e), information reported''; and

(2) in the heading for the section, by striking ''miscellaneous provisions'' and inserting ''additional provisions regarding access to information; miscellaneous provisions''.

KENNEDY AMENDMENTS NOS. 606–607

(Ordered to lie on the table.)

Mr. KENNEDY submitted two amendments intended to be proposed by him to amendment No. 603 proposed by Mr. MCCONNELL to amendment No. 596 proposed by Mr. GORTON to the bill H.R. 956, supra; as follows:

AMENDMENT NO. 606

Strike the material from page 8, line 20 through page 10, line 17, and insert in lieu thereof the following:

(a) IN GENERAL.—Except as provided in subsections (b) and (c), this subtitle shall apply with respect to any health care liability action brought in any Federal or State court, except that this subtitle shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) PREEXEMPTION.—The provisions of this subtitle shall not be construed to preempt any state law, but shall govern any question with respect to which there is no state law.

AMENDMENT NO. 607

In lieu of the matter proposed to be inserted, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Liability Reform Act of 1995''.

TITLE I—LIABILITY REFORM

SEC. 101. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 102, this title shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this title shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this title shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(3) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

(b) DEFINITIONS.—In this Act, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be license or certified by the State to engage in the delivery of such services in the State.

(5) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(6) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a cause of action brought in a State or Federal court against a health care provider or health care professional by which the plaintiff alleges a medical malpractice claim.

(7) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means a claim brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort;

(B) any claim based on an allegation that a product is defective that is brought against any individual or entity that is not a health care professional or health care provider; or

(C) any claim brought pursuant to any remedies or enforcements provision of law.

SEC. 102. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.

(a) APPLICATION TO MALPRACTICE CLAIMS UNDER PLANS.—Prior to or immediately following the commencement of any medical malpractice action, the parties shall participate in the alternative dispute resolution system administered by the State under subsection (b). Such participation shall be in lieu of any other provision of Federal or State law or any contractual agreement made by or on behalf of the parties prior to the commencement of the medical malpractice action.

(b) ADOPTION OF MECHANISM BY STATE.—Each State shall—

(1) maintain or adopt at least one of the alternative dispute resolution methods satisfying the requirements specified under subsection (c) and (d) for the resolution of medical malpractice claims arising from the provision of (or failure to provide) health care services to individuals enrolled to a health plan; and

(2) clearly disclose to enrollees (and potential enrollees) the availability and procedures for consumer grievances, including a description of the alternative dispute resolution method or methods adopted under this subsection.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Board shall, by regulation, development alternative dispute resolution methods for the use by States in resolving medical malpractice claims under subsection (a). Such methods shall include at least the following:

(A) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution process which may, subject to subsection (d), result in a final decision as to facts, law, liability or damages.

(B) CLAIMANT-REQUESTED BINDING ARBITRATION.—For claims involving a sum of money that falls below a threshold amount set by the Board, the use of arbitration not subject to subsection (d). Such binding arbitration shall be at the sole discretion of the claimant.

(C) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(D) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement. If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(E) CERTIFICATE OF MERIT.—The requirement that a medical malpractice plaintiff submit to the court before trial a written report by a qualified specialist that includes the specialist's determination that, after a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Board shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) provides for timely resolution of claims;

(C) provides for the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution for individuals enrolled in plans.

(3) WAIVER AUTHORITY.—Upon application of a State, the Board may grant the State the authority to fulfill the requirement of subsection (b) by adopting a mechanism other than a mechanism established by the Board pursuant to this subsection, except that such mechanism must meet the standards set forth in paragraph (2).

(d) FURTHER REDRESS.—Except with respect to the claimant-requested binding arbitration method set forth in subsection (c)(1)(B), and notwithstanding any other provision of a law or contractual agreement, a plan enrollee dissatisfied with the determination reached as a result of an alternative dispute resolution method applied under this section may, after the final resolution of the enrollee's claim under the method, bring a cause of action to seek damages or other redress with respect to the claim to the extent otherwise permitted under State law. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during such procedures, unless otherwise admissible under State law.

SEC. 103. LIMITATION ON AMOUNT OF ATTORNEY'S CONTINGENCY FEES.

(a) IN GENERAL.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such action (including the resolution of the claim that is the subject of the action under any alternative dispute resolution system) in excess of—

(1) 33⅓ percent of the first $150,000 of the total amount recovered by judgment or settlement in such action; plus

(2) 25 percent of any amount recovered above the amount described in paragraph (1);

unless otherwise determined under State law. Such amount shall be computed after deductions are made for all the expenses associated with the claim other than those attributable to the normal operating expenses of the attorney.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) may, in the discretion of the court, be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 104. REDUCTION OF AWARDS FOR RECOVERY FROM COLLATERAL SOURCES.

(a) REDUCTION OF AWARD.—The total amount of damages recovered by a plaintiff in a medical malpractice liability action shall be reduced by an amount that equals—

(1) the amount of any payment which the plaintiff has received or to which the plaintiff is presently entitled on account of the same injury for which the damages are awarded, including payment under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other program, if the payment is intended to compensate the plaintiff for the same injury for which damages are awarded; less

(2) the amount of any premiums or any other payments that the plaintiff has paid to be eligible to receive the payment described in paragraph (1) and any portion of the award subject to a subrogation lien or claim.

(b) SUBROGATION.—The court may reduce a subrogation lien or claim described in subsection (a)(2) by an amount representing reasonable costs incurred in securing the award subject to the lien or claim.

(c) INAPPLICABILITY OF SECTION.—This section shall not apply to any case in which the court determines that the reduction of damages pursuant to subsection (a) would compound the effect of any State law limitation on damages so as to render the plaintiff less than fully compensated for his or her injuries.

SEC. 105. PERIODIC PAYMENT OF AWARDS.

(a) IN GENERAL.—A party to a medical malpractice liability action may petition the court to instruct the trier of fact to award any future damages on an appropriate periodic basis. If the court, in its discretion, so instructs the trier of fact, and damages are awarded on a periodic basis, the court may require the defendant to purchase an annuity or other security instrument (typically based on future damages discounted to present value) adequate to assure payments of future damages.

(b) FAILURE OR INABILITY TO PAY.—With respect to an award of damages described in subsection (a), if a defendant fails to make payments in a timely fashion, or if the defendant becomes or is at risk of becoming insolvent, upon such a showing the claimant may petition the court for an order requiring that remaining balance be discounted to present value and paid to the claimant in a lump-sum.

(c) MODIFICATION OF PAYMENT SCHEDULE.—The court shall retain authority to modify the payment schedule based on changed circumstances.

(d) FUTURE DAMAGES DEFINED.—As used in this section, the term ''future damages'' means any economic or noneconomic loss other than that incurred or accrued as of the time of judgment.

SEC. 106. CONSTRUCTION.

Nothing in this title shall be construed to preempt any State law that sets a maximum limit on total damages.

PART 2—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 201. STATE MALPRACTICE REFORM DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—The Secretary shall award grants to States for the establishment of malpractice reform demonstration projects in accordance with this section. Each such project shall be designed to assess the fairness and effectiveness of one or more of the following models:

(1) No-fault liability.

(2) Enterprise liability.

(3) Practice guidelines.

(b) DEFINITIONS.—For purposes of this section:

(1) MEDICAL ADVERSE EVENT.—The term ''medical adverse event'' means an injury that is the result of medical management as opposed to a disease process that creates disability lasting at least one month after discharge, or that prolongs a hospitalization for more than one month, and for which compensation is available under a no-fault medical liability system established under this section.

(2) NO-FAULT MEDICAL LIABILITY SYSTEMS.—The terms ''no-fault medical liability system'' and ''system'' mean a system established by a State receiving a grant under this section which replaces the common law tort liability system for medical injuries with respect to certain qualified health care organizations and qualified insurers and which meets the requirements of this section.

(3) PROVIDER.—The term ''provider'' means physician, physician assistant, or other individual furnishing health care services in affiliation with a qualified health care organization.

(4) QUALIFIED HEALTH CARE ORGANIZATION.—The term ''qualified health care organization'' means a hospital, a hospital system, a managed care network, or other entity determined appropriate by the Secretary which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(5) QUALIFIED INSURER.—The term ''qualified insurer'' means a health care malpractice insurer, including a self-insured qualified health care organization, which elects in a State receiving a grant under this section to participate in a no-fault medical liability system and which meets the requirements of this section.

(6) ENTERPRISE LIABILITY.—The term ''enterprise liability'' means a system in which State law imposes malpractice liability on

the health plan in which a physician participates in place of personal liability on the physician in order to achieve improved quality of care, reductions in defensive medical practices, and better risk management.

(7) PRACTICE GUIDELINES.—The term ''practice guidelines'' means guidelines established by the Agency for Health Care Policy and Research pursuant to the Public Health Service Act or this Act.

(c) APPLICATIONS BY STATES.—

(1) IN GENERAL.—Each State desiring to establish a malpractice reform demonstration project shall submit an application to the Secretary at such time and in such manner as the Secretary shall require.

(2) CONTENTS OF APPLICATION.—An application under paragraph (1) shall include—

(A) an identification of the State agency or agencies that will administer the demonstration project and be the grant recipient of funds for the State;

(B) a description of the manner in which funds granted to a State will be expended and a description of fiscal control, accounting, and audit procedures to ensure the proper dispersal of and accounting for funds received under this section; and

(C) such other information as the Secretary determines appropriate.

(3) CONSIDERATION OF APPLICATIONS.—In reviewing all applications received from States desiring to establish malpractice demonstration projects under paragraph (1), the Secretary shall consider—

(A) data regarding medical malpractice and malpractice litigation patterns in each State;

(B) the contributions that any demonstration project will make toward reducing malpractice and costs associated with health care injuries;

(C) diversity among the populations serviced by the systems;

(D) geographic distribution; and

(E) such other criteria as the Secretary determines appropriate.

(d) EVALUATION AND REPORTS.—

(1) BY THE STATES.—Each State receiving a grant under this section shall conduct ongoing evaluations of the effectiveness of any demonstration project established in such State and shall submit an annual report to the Secretary concerning the results of such evaluations at such times and in such manner as the Secretary shall require.

(2) BY THE SECRETARY.—The Secretary shall submit an annual report to Congress concerning the fairness and effectiveness of the demonstration projects conducted under this section. Such report shall analyze the reports received by the Secretary under paragraph (1).

(e) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

(2) LIMITATIONS ON EXPENDITURES.—

(A) ADMINISTRATIVE EXPENSES.—Not more than 10 percent of the amount of each grant awarded to a State under this section may be used for administrative expenses.

(B) WAIVER OF COST LIMITATIONS.—The limitation under subparagraph (A) may be waived as determined appropriate by the Secretary.

(f) ELIGIBILITY FOR NO-FAULT DEMONSTRATION.—A State is eligible to receive a no-fault liability demonstration grant if the application of the State under subsection (c) includes—

(1) an identification of each qualified health care organization selected by the State to participate in the system, including—

(A) the location of each organization;

(B) the number of patients generally served by each organization;

(C) the types of patients generally served by each organization;

(D) an analysis of any characteristics of each organization which makes such organization appropriate for participation in the system;

(E) whether the organization is self-insured for malpractice liability; and

(F) such other information as the Secretary determines appropriate;

(2) an identification of each qualified insurer selected by the State to participate in the system, including—

(A) a schedule of the malpractice insurance premiums generally charged by each insurer under the common law tort liability system; and

(B) such other information as the Secretary determines appropriate;

(3) a description of the procedure under which qualified health care organizations and insurers elect to participate in the system;

(4) a description of the system established by the State to assure compliance with the requirements of this section by each qualified health care organization and insurer; and

(5) a description of procedures for the preparation and submission to the State of an annual report by each qualified health care organization and qualified insurer participating in a system that shall include—

(A) a description of activities conducted under the system during the year; and

(B) the extent to which the system exceeded or failed to meet relevant performance standards including compensation for and deterrence of medical adverse events.

(g) ELIGIBILITY FOR ENTERPRISE LIABILITY DEMONSTRATION.—A State is eligible to receive an enterprise liability demonstration grant if the State—

(1) has entered into an agreement with a health plan (other than a fee-for-service plan) operating in the State under which the plans assumes legal liability with respect to any medical malpractice claim arising from the provision of (or failure to provide) services under the plan by any physician participating in the plan; and

(2) has provided that, under the law of the State, a physician participating in a plan that has entered into an agreement with the State under paragraph (1) may not be liable in damages or otherwise for such a claim and the plan may not require such physician to indemnify the plan for any such liability.

(h) ELIGIBILITY FOR PRACTICE GUIDELINES DEMONSTRATION.—A State is eligible to receive a practice guidelines demonstration grant if the law of the State provides that in the resolution of any medical malpractice action, compliance or non-compliance with an appropriate practice guideline shall be admissible at trial as a rebuttable presumption regarding medical negligence.

Mr. KENNEDY. Mr. President, at an appropriate time on Monday, I intend to offer two second-degree amendments to the McConnell amendment. I have already described them briefly; one would clarify that this bill does not preempt State law, while the other would be a complete substitute consisting of the malpractice subtitle of the Health Care Reform Act favorably reported by the Labor Committee last year.

I will file them at this time so that they are available for review by the membership.

SNOWE AMENDMENT NO. 608

Ms. SNOWE proposed an amendment to amendment No. 603 proposed by Mr. MCCONNELL to the amendment No. 596 proposed by Mr. GORTON to the bill H.R. 956, supra; as follows:

On p. 14, line 22, insert:

In section 15 of the amendment, strike subsection (e) and insert the following new subsection:

(e) LIMITATION ON AMOUNT.—

(1) IN GENERAL.—The amount of punitive damages that may be awarded to a claimant in a health care liability action that is subject to this title shall not exceed 2 times the sum of—

(A) the amount awarded to the claimant for economic loss; and

(B) the amount awarded to the claimant for noneconomic loss.

(2) APPLICATION BY COURT.—This subsection shall be applied by the court and the application of this subsection shall not be disclosed to the jury.

KYL AMENDMENT NO. 609

Mr. KYL proposed an amendment to amendment No. 603 proposed by Mr. MCCONNELL to amendment No. 596 proposed by Mr. GORTON to the bill, H.R. 956, supra; as follows:

SEC. . FAIR COMPENSATION FOR NONECONOMIC LOSSES AND PUNITIVE DAMAGES.

(a) FULL COMPENSATION FOR NONECONOMIC LOSSES.—Notwithstanding any other provision of this Act, an attorney who represents, on a contingency fee basis, a claimant in a civil action in a Federal or State court may not charge, demand, receive, or collect for services rendered in connection with such action on any amount recovered by judgment or settlement under such action for noneconomic losses in excess of 25 percent of the first $250,000 (or portion thereof) recovered, based on after-tax recovery.

(b) ATTORNEY FEES FOR PUNITIVE DAMAGES.—With respect to any award or settlement for punitive damages, an attorney's fee, if any, received by an attorney who represents, on a contingency fee basis, a claimant in a civil action in a Federal or State court shall be established by the court based on the work performed by the attorney, and shall be ethical and reasonable. It shall be a rebuttable presumption that an ethical and reasonable attorney's fee in such an action is 25 percent of such award for punitive damages.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of losses or damages, whether through judgment or settlement.

COLORADO RIVER BASIN SALINITY CONTROL AMENDMENTS ACT

DOMENICI AMENDMENT NO. 610

Mr. KYL (for Mr. DOMENICI) proposed an amendment to the bill (S. 523) to amend the Colorado River Basin Salinity Control Act to authorize additional measures to carry out the control of salinity upstream of Imperial Dam in a cost-effective manner, and for other purposes; as follows:

On page 7, strike ''such paragraph'' on line 1, and insert the following: ''such paragraph.